

# Data Capture Form



Lower Abbey Street  
Dublin 1 Ireland  
Telephone 01 704 2000  
Fax 01 704 1900  
www.irishlife.ie

## Product Selection

Life Home  Life Cash

**BLOCK**

Life Home  Life Cash

## Personal Details

### First person to be covered

Name

Date of birth

Marital Status

Address

Country of birth

Previous surname (if any)

Precise occupation

Current level of earnings

€

Contact phone no

home

work

mobile

Email address

### Second person to be covered

Name

Date of birth

Marital Status

Country of birth

Previous surname (if any)

Precise occupation

Current level of earnings

€

Contact phone no

home

work

mobile

Email address

## Policy Owner Details (if different to person to be covered)

Policy owners name or Business name

Personal policy owners DOB

Insurable interest

Address of policy owner / business

## Trust Information (if written in trust)

Type of trust Flexible  Shareholders  Partners

Appointer's name

Appointer's date of birth

Address of appointer

## Alteration Authority

Assuming the plan owner is not different from the persons covered, and the plan is not to be assigned or written in trust, please confirm who can authorise transaction?

All plan owners only  Any one plan owner  First person covered  Second person covered

Note: This does not apply if you are reducing your benefits, or cancelling/cashing in your plan.

## Further information

Is this application in connection with a mortgage? YES  NO

If YES, is the cover amount less than or equal to the mortgage amount? YES  NO

Is the policy to be assigned immediately on issue to the lender? YES  NO

## Product details

Term of cover  years For Life Cash Cover, the maximum term for Specified Illness Cover is 25 years and the expiry age for Specified Illness Cover is age 65.  
For Life Home Cover, the maximum term for Specified Illness Cover is 35 years and the expiry age for Specified Illness Cover is age 75.

	First person	Second person
Life Cover	€ <input type="text"/>	€ <input type="text"/>
Specified Illness Cover	€ <input type="text"/>	€ <input type="text"/>

Note: Specified Illness Cover can be any amount up to but not exceeding the amount of Life Cover. This applies to both Life Home Cover and Life Cash Cover.

Accelerated or  Independent  Accelerated or  Independent

Note: Independent Specified Illness cover applies to Life Cash Cover only

Guaranteed Cover Again YES  NO  Note: Guaranteed Cover Again applies to Life Cash Cover only. You can only take out Guaranteed Cover Again if you are under 55. Guaranteed Cover Again is only available on Specified Illness Cover moved into a unit-linked plan. Subject to a maximum of €500,000 on Specified Illness Cover and €1,000,000 on Life Cover.

Inflation protection YES  NO

Is the cover to start immediately YES  NO  Note: Inflation protection applies to Life Cash Cover (non block) only

## Payment details

3rd party bank account YES  NO

On what date in the month are debits to be collected  of each month (1 - 28)

Bank Sort Code  A/C No

Name of account

Name & address of Bank

## Other Information

Is this Business Replacement? YES  NO

Do you want Information on other IL&P products YES  NO

**THIS FORM TO BE USED AFTER 1 OCTOBER 2004**

# Health questions for protection cases

	First person to be covered	Second person to be covered
Please give the name and address of your doctor.	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
If you have changed doctor in the last year, please give the name and address of your previous doctor as well.	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
<b>This question need only be asked on non-Block Life Cash Cover applications</b>		
Are you currently proposing for life assurance or critical illness cover with this or any other life office?	Type of cover Offices proposed to <input style="width: 90%;" type="text"/>	Type of cover Offices proposed to <input style="width: 90%;" type="text"/>
Do you have more than €130000 life cover in force with Irish Life or Progressive Life?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Do you have more than €65000 specified illness cover in force with Irish Life or Progressive Life?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Height and Weight.	<input style="width: 45%;" type="text"/> feet <input style="width: 45%;" type="text"/> inches	<input style="width: 45%;" type="text"/> feet <input style="width: 45%;" type="text"/> inches
	<input style="width: 45%;" type="text"/> stone <input style="width: 45%;" type="text"/> pounds	<input style="width: 45%;" type="text"/> stone <input style="width: 45%;" type="text"/> pounds
or alternatively	<input style="width: 45%;" type="text"/> cms <input style="width: 45%;" type="text"/> kilos	<input style="width: 45%;" type="text"/> cms <input style="width: 45%;" type="text"/> kilos
Have you smoked tobacco of any kind in the past 12 months or do you intend to smoke in the future?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Tobacco consumption (all types of tobacco) per day	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
It is our practice to carry out occasional tests to confirm smoker status.		
Alcohol consumption (total number of units) per week	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
<small>Unit Guide: Pint Beer - 2.0 units, Bottle Beer - 1.5 units, Glass beer - 1.0 units, Measure spirits - 1.0 units, Bottle wine - 7.0 units, Glass wine - 1.0 units.</small>		
<b>Have you ever suffered from or had treatment for</b>		
If you answer 'YES' to any question please give details (including name of condition, dates and medication) in the section entitled "Other Medical Information" across the page.		
(a) heart disorder, stroke, rheumatic fever, high blood pressure or blood disorder?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(b) asthma, bronchitis or another lung disorder?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(c) multiple sclerosis, numbness, epilepsy, blackouts, paralysis or double vision?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(d) kidney or bladder disorder?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(e) diabetes or a stomach, liver or bowel disorder?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(f) cancer or any other growth or tumour?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(g) a mental or nervous disorder?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(h) slipped disc, back, arthritic or muscular disorder?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(i) disorder of the eyes or ears (other than wearing prescribed glasses or contact lenses)?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
(j) any other illness, injury or condition for which you have had medical advice in the last five years?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Have you had a surgical operation in the last five years?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

Have you in the last five years had or been advised to have any special investigations, blood or laboratory tests?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Are you currently taking prescribed drugs, medicines, tablets or other treatment?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Are you currently unwell or receiving medical treatment of any kind, which you have not mentioned in the answers given above?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Have you ever taken drugs for other than medical purposes?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Have you ever tested positively for HIV or AIDS, Hepatitis B or Hepatitis C or are you waiting for the result of this kind of test? If YES, please supply details	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Have you any intention or prospect of taking part in any kind of dangerous activity as a result of your hobbies or pastimes? If YES, please supply names of hobbies and details	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Have you any intention or prospect of living or travelling outside the EU other than for holidays? If YES, please supply names of countries, reason for visit and duration of stay.	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Have you ever applied to Irish Life or any other insurer and been refused, postponed or accepted on special terms for life cover, disability or illness cover?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												
Have your parents or any of your brothers or sisters suffered or died from heart disease including cardiomyopathy, stroke, kidney disease, cancer, multiple sclerosis, Huntington's chorea, polycystic kidneys, polyposis of the colon or other hereditary disorder before age 60? (If you are adopted please answer NO to this question) If your relative had <b>cancer</b> , please tell us which part of the body was affected first.	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>																																												
	<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%;">Condition suffered</th> <th style="width: 15%;">Age when it started</th> <th style="width: 15%;"></th> <th style="width: 15%;">Condition suffered</th> <th style="width: 15%;">Age when it started</th> </tr> </thead> <tbody> <tr> <td rowspan="3">If living</td> <td>Father</td> <td><input style="width: 90%;" type="text"/></td> <td rowspan="3"></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> <tr> <td>Mother</td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> <tr> <td>Brothers</td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> <tr> <td rowspan="3"></td> <td>Sisters</td> <td><input style="width: 90%;" type="text"/></td> <td rowspan="3"></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> <tr> <td>Father</td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> <tr> <td>Mother</td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> <tr> <td rowspan="3">If dead</td> <td>Brothers</td> <td><input style="width: 90%;" type="text"/></td> <td rowspan="3"></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> <tr> <td>Sisters</td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> <td><input style="width: 90%;" type="text"/></td> </tr> </tbody> </table>		Condition suffered	Age when it started		Condition suffered	Age when it started	If living	Father	<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Mother	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Brothers	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>		Sisters	<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Father	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Mother	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	If dead	Brothers	<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	Sisters	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
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Quick Underwriting Medical Questionnaire completed?	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>																																												